

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00585

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>0605</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> <u>22122</u>	
c. LENGTH OF STAY IN 1b <u>5 mos. 5 days</u>		d. STREET ADDRESS <u>301 E. College Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN SHORE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillie</u> <u>-</u> <u>Abbott</u>		4. DATE OF DEATH Month Day Year <u>January</u> <u>15</u> <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 29, 1883</u> 9. AGE (in years last birthday) <u>74 7/16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dressmaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Abbott</u>	
14. MOTHER'S MAIDEN NAME <u>Caroline Malone</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>RECORDS: EASTERN SHORE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>-</u> (a), stating the underlying cause last. (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture neck right femur.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Apparently fell from chair in hospital</u>	
20c. TIME OF INJURY Month, Day, Year <u>7:30 a.m.</u> <u>12-28-</u> <u>19 59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	20f. (City or town) (County) (State) <u>Cambridge</u> <u>Dor.</u> <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1/15/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-18-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson</u> ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 18 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0000

FILED
COUNTY OF

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Usual Residence: _____

7. Cause of Death: _____

8. Manner of Death: _____

9. Signature of Medical Examiner: _____

10. Date: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00585

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) First Catherine Middle Lampus Last Bassler		4. DATE OF DEATH Month January Day 27 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 29, 1869
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Christian Lampus		14. MOTHER'S MAIDEN NAME Barbara Meyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. George J. Rimm, Fishing Creek, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 MOS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/18, 1957 to 1/27, 1960 that I last saw the deceased alive on 1/4, 1960 and that death occurred at 9:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. E. GUNBY JR. M.D.		ADDRESS (Street, city or town, state) 105 CHURCH ST. DATE SIGNED 1/28/60	
PHYSICIAN'S NAME (Type) W. E. GUNBY JR.		Cambridge Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 30, 1960	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Vernon, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Emeth R. Shuman		24a. REC'D BY REGISTRAR FEB 1 '60 24b. REGISTRAR'S SIGNATURE Charles S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE

DECEASED

RESIDENT OF

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

TIME OF BURIAL

PLACE OF INTERMENT

DATE OF INTERMENT

TIME OF INTERMENT

PLACE OF CREMATION

DATE OF CREMATION

TIME OF CREMATION

PLACE OF REINTERMENT

DATE OF REINTERMENT

TIME OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

TIME OF REINTERMENT

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

0607 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural			c. LENGTH OF STAY IN 1b Life		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Finchville			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Henry Middle Clay Last Batson			4. DATE OF DEATH Month January Day 5 Year 1960		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1886	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee of State Roads Commission			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.
13. FATHER'S NAME Jeremiah Batson			14. MOTHER'S MAIDEN NAME Margaret Evans		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. —		
17. INFORMANT Virgie C. Batson, Rhodesdale, Md., R.F.D.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) Arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 8 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE			
20c. TIME OF INJURY Month 19 Hour a. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 3-28-1958 to 1-5-1960 , that I last saw the deceased alive on 1-4-1960 , and that death occurred at 7 A. M. from the causes and on the date stated above.					
ACTUAL SIGNATURE John C. Rawlins		ADDRESS (Street, city or town, state) 202 High St., Seaford, Del		DATE SIGNED 1-9-60	
PHYSICIAN'S NAME (Type) John C. Rawlins, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 9, 1960	22c. NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery	22d. LOCATION (City, town, or county) (State) Near Federalsburg, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland			24a. REC'D BY REGISTRAR DATE JAN 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEED

1911-1912

THE COMMISSIONER

JOE M. COE

Blank form area with faint horizontal lines for text entry.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00588

0608

1. PLACE OF DEATH o. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CAMBRIDGE</u>				c. LENGTH OF STAY IN TB <u>3 MOS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MAUDE</u> Middle <u>MARIE</u> Last <u>BENNETT</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 5, 1881</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u>		IF UNDER 24 HRS. Hours <u>10</u> Min. <u>19</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND (Somerset Co)</u>	
12. CITIZEN OF WHAT COUNTRY? <u>S.A.</u>							
13. FATHER'S NAME <u>BENJAMIN HITCH</u>				14. MOTHER'S MAIDEN NAME <u>ELLA CANTWELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>WILLIAM BENNETT, 100 SYLVIA ST. SALISBURY. (husband)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO (b) <u>UNKNOWN</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>UNKNOWN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>STRANGULATED FEMORAL HERNIA HERNIOGRAPHY</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>OCT 14</u> , 19 <u>59</u> , to <u>JAN 10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JAN 8</u> , 19 <u>60</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>EASTERN SHORE STATE HOSP. CAMBRIDGE, MD.</u> DATE SIGNED <u>1/10/60</u>							
ACTUAL SIGNATURE <u>George H. Holloway</u> M.D.							
PHYSICIAN'S NAME (Type) <u>GEORGE H. HOLLOWAY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 12, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u>				24a. REC'D BY REGISTRAR <u>JAN 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00583

0587

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reids Grove - Rhodesdale, R.F.D.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle H. Last Cannon				4. DATE OF DEATH Month January Day 25 Year 1960			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED	8. DATE OF BIRTH About 1876	9. AGE (In years last birthday) About 82 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Labor (Farm)		11. BIRTHPLACE (State or foreign country) Unknown Dorchester Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Elisha Cannon				14. MOTHER'S MAIDEN NAME Unknown Mary (maiden name unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Records Cambridge Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Mace Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Mace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 28, 1960		22c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR JAN 29 '60		24b. REGISTRAR'S SIGNATURE Arthur L. King	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1982

FOR STATE
HEALTH DEPT.

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

MANNER OF DEATH: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RELIGION: [illegible]

US BIRTH: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RELIGION: [illegible]

US BIRTH: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RELIGION: [illegible]

US BIRTH: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00590

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b entire life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Noble Middle Stewart Last Cannon		4. DATE OF DEATH Month January Day 9 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 28, 1894
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Waterman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William S. Cannon		14. MOTHER'S MAIDEN NAME Lula Condon Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes World War 1		16. SOCIAL SECURITY NO 218-34-2915	
17. INFORMANT Mrs. Robert L. Dail, Glasgow St., Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c) -- --		INTERVAL BETWEEN ONSET AND DEATH 5 mins. unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obstructive tumor colon splenic flexure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -- -- --	
20c. TIME OF INJURY Month, Day, Year Hour a. m. -- -- 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- --		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-10-59 , 19__ to 1-9-60 , 19__, that I last saw the deceased alive on 1-9-60 , 19__, and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Eldridge H. Wolff		ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md.	
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.		DATE SIGNED 1-10-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 11, 1960	22c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Cambridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Shuman		24a. REC'D BY REGISTRAR DATE JAN 15 '60	
ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be furnished for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0589 CERTIFICATE OF DEATH

Reg. Dist. No.

00591

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN IB 28 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital Inc.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dawn Middle Michelle Last Chester		4. DATE OF DEATH Month January Day 26 Year 19 60	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-25-60
9. AGE (In years last birthday) yrs. 4		10. IF UNDER 1 YEAR Months 4 Days 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Leon Chester Jr.		14. MOTHER'S MAIDEN NAME Marie Pinkett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Marie Chester		Address Rhodesdale, Md. Route # 1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atelectasis DUE TO (c) ---			INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour --- o. m. --- p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Net-white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from 1-25 , 19 60 , to 1-26 , 19 60 , that I last saw the deceased alive on 1-26 , 19 60 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Eldridge H. Wolff		ADDRESS (Street, city or town, state) Cambridge Md.	
PHYSICIAN'S NAME (Type) Dr. Eldridge H. Wolff		DATE SIGNED 1-26-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) 1-27-60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Rhodesdale A.M.E. Zion		22d. LOCATION (City, town, or county) (State) Rhodesdale Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leon Chester Jr.		24. REC'D BY REGISTRAR ---	
ADDRESS Rhodesdale Md.		24b. REGISTRAR'S SIGNATURE William S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00592

0590

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>212 West End Ave</u>				d. STREET ADDRESS <u>212 West End Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Anne</u> Middle <u>Kirby</u> Last <u>Clift</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 4, 1886</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Kirby</u>				14. MOTHER'S MAIDEN NAME <u>Mary Weber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>Unknown</u>		17. INFORMANT Address <u>Mrs Everett Creighton Cambridge Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Phlebotrombosis, leg veins</u> DUE TO (c) <u>Recurrent adenocarcinoma of colon</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>?</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 11, 1959</u> , to <u>Jan 20, 1960</u> , that I last saw the deceased alive on <u>Jan 19, 1960</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>LeCompte</u> M.D.				ADDRESS (Street, city or town, state) <u>1 Locust St Cambridge Md</u>			
DATE SIGNED <u>1/21/60</u>							
PHYSICIAN'S NAME (Type) <u>Cambridge Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 22, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 28 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00593

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> 0591 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> d. STREET ADDRESS <u>1 Moores Ave. Ext.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Roosevelt</u> Middle <u>Coleman</u> Last <u>Coleman</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>9</u> Year <u>19 60</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>July, 26, 1904</u>		9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Coleman</u>					
14. MOTHER'S MAIDEN NAME <u>Rheta Wheatley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>					
16. SOCIAL SECURITY NO. <u>217-10-8450</u>		17. INFORMANT Address <u>Pearl Coleman Moores Ave. Cambridge, Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> <u>981x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Gun shot wound neck.</u> (c) <u> </u> DUE TO (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was shot with 16g. shotgun by Charles Bryan.</u>		20c. TIME OF INJURY Month, Day, Year <u>9:45</u> a. m. <u>1/9/</u> 19 <u>60</u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Cambridge, Dor. Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1/12/60</u>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/14/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Cambridge, Dor. Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>StClair Cambridge, Md.</u>					
24a. REC'D BY REGISTRAR <u>JAN 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00594

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> 0609 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock - Rural</u> c. LENGTH OF STAY IN TB <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Near Harrison Ferry</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock - Rural</u> d. STREET ADDRESS <u>Near Harrison Ferry</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Franklin</u> Last <u>Corkran</u>				4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1960</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 7, 1959</u>		9. AGE (In years last birthday) yrs. <u>4</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>3</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Easton, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Grover Corkran, Jr.</u>						14. MOTHER'S MAIDEN NAME <u>Norma Donovan</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Grover Corkran, Jr., Hurlock, Md., RFD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> DUE TO <u>Acute respiratory infection</u> Conditions, if any, which gave rise to immediate cause (b) <u>Acute respiratory infection</u> (c) <u>Acute respiratory infection</u> DUE TO <u>Acute respiratory infection</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute respiratory infection</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <u>John Mace Jr.</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) <u>John Mace Jr.</u>						DATE SIGNED <u>1/10/60</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Jan. 11, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Near Williamsburg, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J.J. Frampton and Son, Federalsburg, Maryland</u>						24a. REC'D BY REGISTRAR DATE <u>JAN 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>					

2080258XV4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.




MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00595

1. PLACE OF DEATH a. COUNTY Dorchester 0610 MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - rural		c. LENGTH OF STAY IN 1b 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hurlock - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Milligantown			d. STREET ADDRESS / Milligantown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Emma Middle Hall Last Kinball Cornish			4. DATE OF DEATH Month January Day 25 Year 19 60		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 1, 1908	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Thomson, Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Simeon Hamilton		
14. MOTHER'S MAIDEN NAME Mattie Lou Ruff			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 253-42-1287			17. INFORMANT Sarah Hobbs, Hurlock, Maryland, R.F.D.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 981 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gun shot wound chest DUE TO (c) 					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was shot by pistol.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 1-25-60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Hurlock		20g. (County) Dor.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/28/60	
EXAMINER'S NAME (Type) John Mace Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 20, 1960	22c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery		22d. LOCATION (City, town, or county) (State) East New Market, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland			24a. REC'D BY REGISTRAR DATE FEB 5 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with Form PM-3. Page 1 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00592

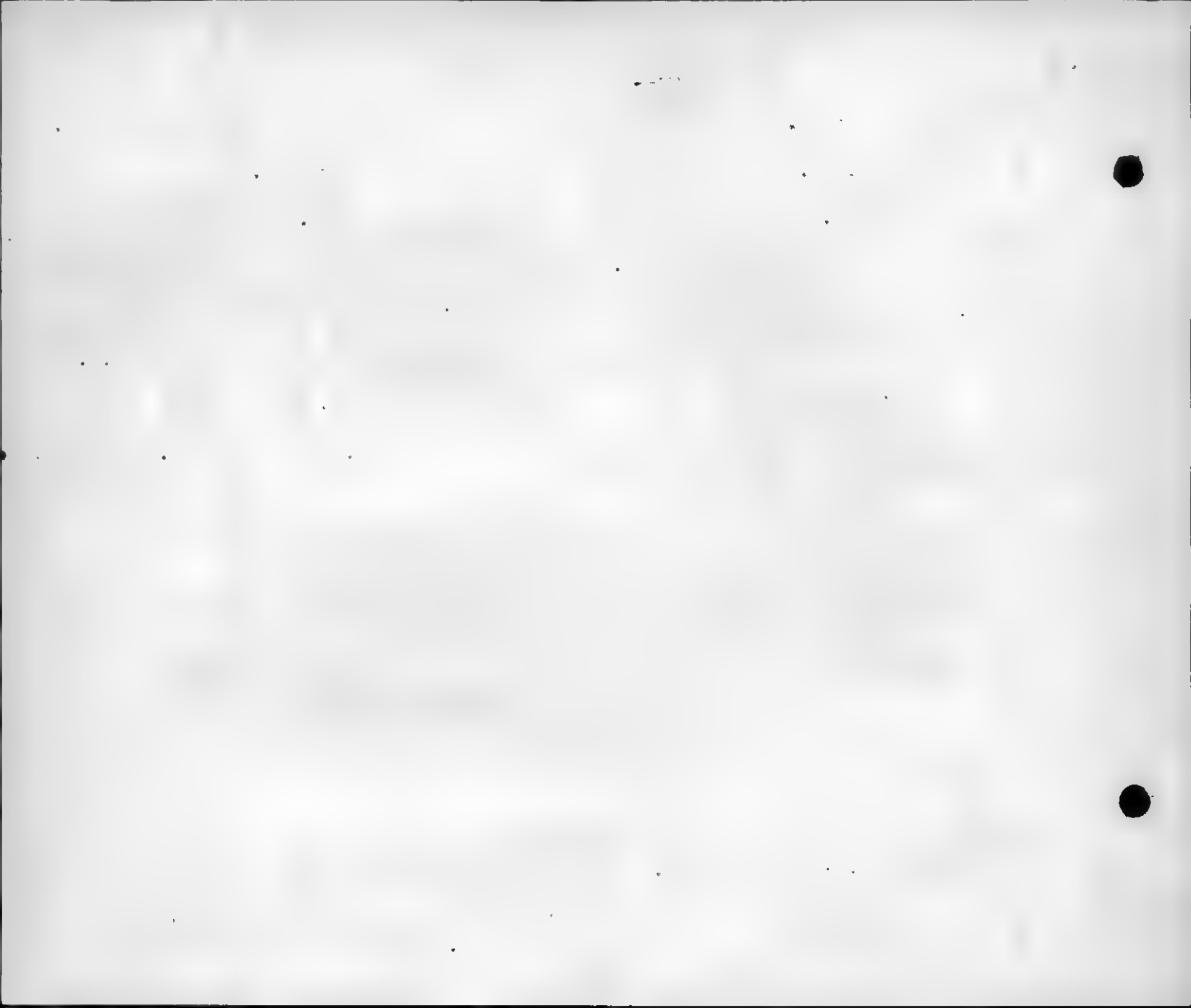
Reg. Dist. No.

0592

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in accordance with 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>100 Locust, St.</u>				d. STREET ADDRESS <u>101 Academy, St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>C.</u> Last <u>Dayton</u>				4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/17/1884</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Dayton</u>				14. MOTHER'S MAIDEN NAME <u>Mary Horseman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Randall Dayton, 101 Academy St., Cambridge, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Dr. John Mace Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>				DATE SIGNED <u>1/4/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market Cem</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

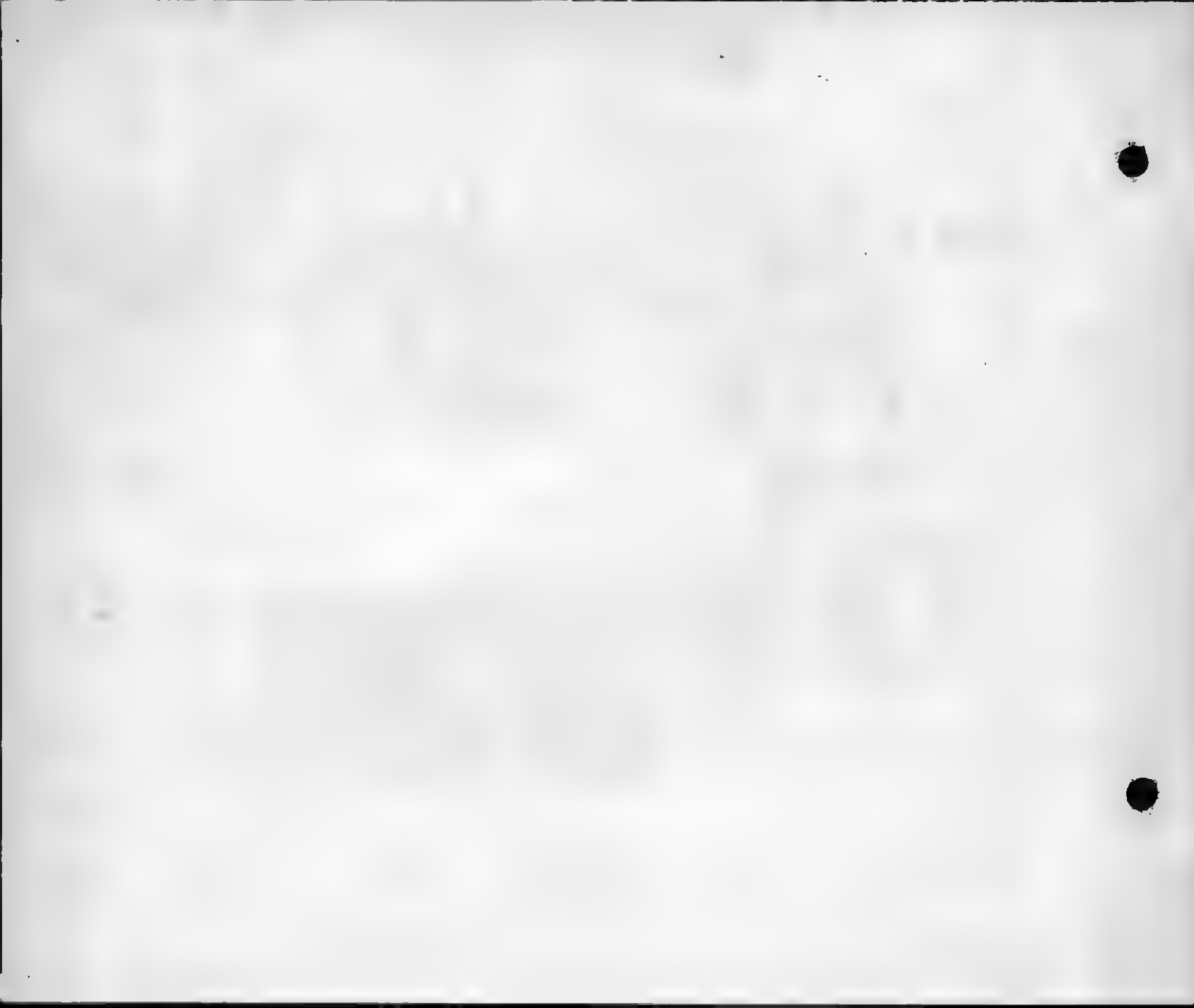
Reg. Dist. No.

00597

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wor.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellington</u>		c. LENGTH OF STAY IN 1b <u>all life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellington</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Corbett Jefferey Elliott</u>		4. DATE OF DEATH Month Day Year <u>1 9 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/2/1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Water</u>	
11. BIRTHPLACE (State or foreign country) <u>Ellington, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Jesse Elliott</u>		14. MOTHER'S MAIDEN NAME <u>Ira Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>—</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John Mace Jr</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/12/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ellington</u>		22d. LOCATION (City, town, or county) (State) <u>Ellington Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Ellington, East New Market, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 14 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Ellington</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form IIM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

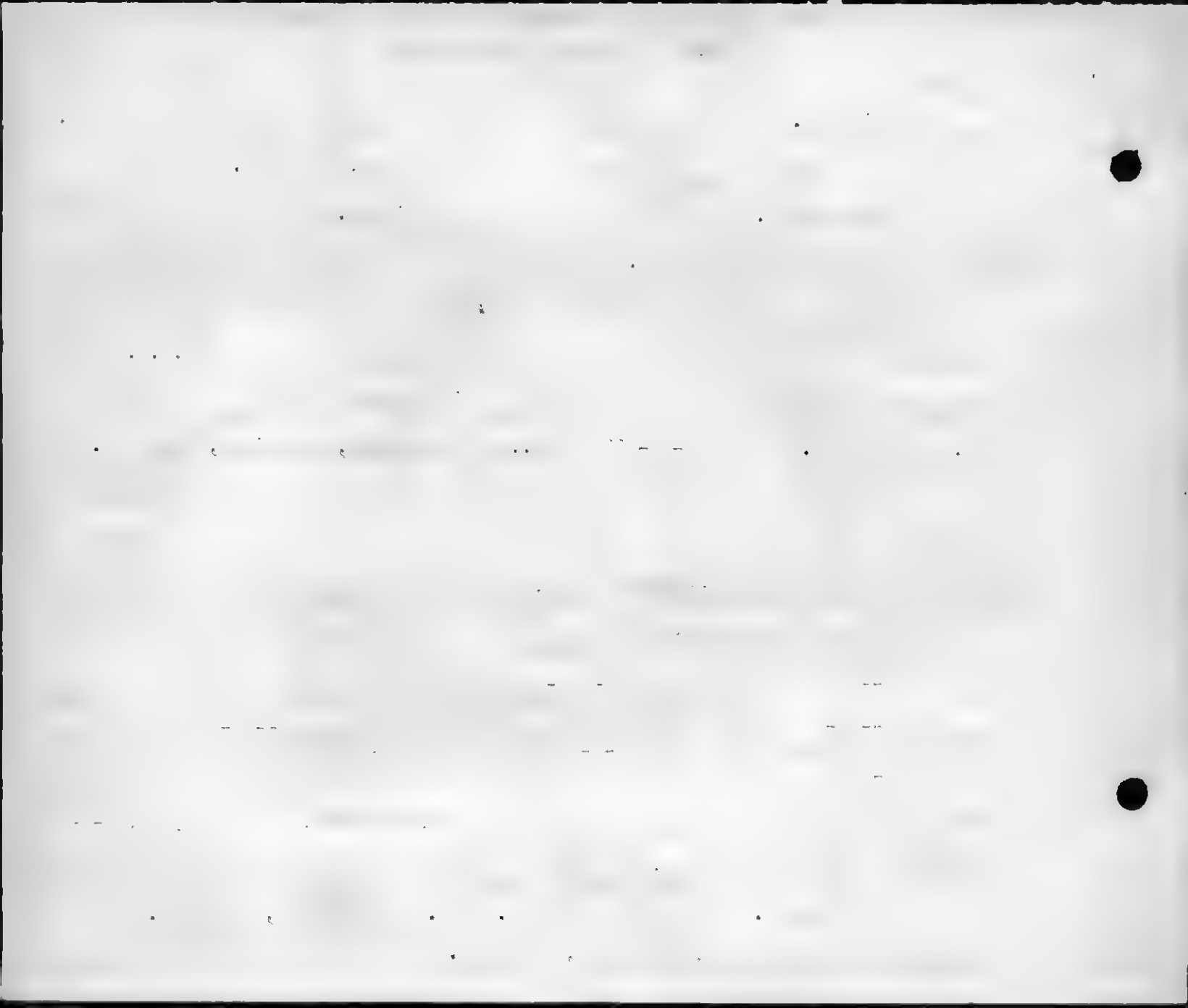
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0593 CERTIFICATE OF DEATH

Reg. Dist. No.

00598

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>16 Muir St.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>W.</u> Last <u>Fowler</u>		4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/4/1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elias Fowler</u>		14. MOTHER'S MAIDEN NAME <u>Daisy Fowler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>211-07-9332</u>	
17. INFORMANT <u>Mrs., Bertha Fowler, Cambridge, Maryland.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>321X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Accident with shock</u> DUE TO (c) <u>Arteriosclerosis, generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>---</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
21. I certify that I attended the deceased from <u>1-6-60</u> , 19 <u> </u> , to <u>1-8-60</u> , 19 <u> </u> , that I last saw the deceased alive on <u>1-8-60</u> , 19 <u> </u> , and that death occurred at <u>2:30A M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 Locust Street, Cambridge, Md.</u> DATE SIGNED <u>1-8-60</u>			
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u>		M.D. <u>15 Locust Street, Cambridge, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/10/60.</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park.</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 14 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Carlton L. Tharr</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0594 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00599**

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Hospital				d. STREET ADDRESS Edgewood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eddie First Fussell Middle Last				4. DATE OF DEATH Month January Day 22 Year 1960			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown		9. AGE (In years last birthday) About 55	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Ant labor		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Cambridge Police Dept., Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Maco Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Maco Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/23/1960		22c. NAME OF CEMETERY OR CREMATORY Anatomical Board University Hosp.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert M. St. Lawrence Jr.</i>				24a. REC'D BY REGISTRAR DATE JAN 28 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

006.0

0612

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS 203 Choptank Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Armetta Last Geoghegan		4. DATE OF DEATH Month January Day 7 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-79
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Brannock		14. MOTHER'S MAIDEN NAME Susan Eliza Maguire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT RECORDS - Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cardiovascular Disease 422.1 DUE TO General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 29 1959 , to January 7, 1960 , that I last saw the deceased alive on January 7, 1960 , and that death occurred at 6:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Ettore DeFilippis M.D. E.S.S. Hospital, Cambridge, Md.		1-7-60	
PHYSICIAN'S NAME (Type) Dr. Ettore DeFilippis			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/9/60	
22c. NAME OF CEMETERY OR CREMATORY DOR MEMO. PK		22d. LOCATION (City, town, or county) (State) CAMBRIDGE MD	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte FUNERAL SERVICE MD		24a. REC'D BY REGISTRAR DATE JAN 11 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kane			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The attending physician and completely filled in by the medical director may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0613 CERTIFICATE OF DEATH

00601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Q.A. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATIE MAY GORDON First Middle Last		4. DATE OF DEATH Jan. 19 1960 Month Day Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/14/79
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Sidney Radcliff		14. MOTHER'S MAIDEN NAME Mary Virginia Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome, cerebral arteriosclerosis 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 12, 1956 to Jan 19, 1960 , that I last saw the deceased alive on Jan 19, 1960 , and that death occurred at 1:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) E.S.S. Hospital, Cambridge, Md. DATE SIGNED 1-19-60			
ACTUAL SIGNATURE Thomas J. Dredge		M.D. E.S.S. Hospital, Cambridge, Md.	
PHYSICIAN'S NAME (Type) Thomas J. Dredge			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 21-60	
22c. NAME OF CEMETERY OR CREMATORY Stonewall		22d. LOCATION (City, town, or county) (State) Stonewall Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Baker, Jr. Butler, Md.		24a. REC'D BY REGISTRAR DATE JAN 25 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

MEDICAL CERTIFICATION



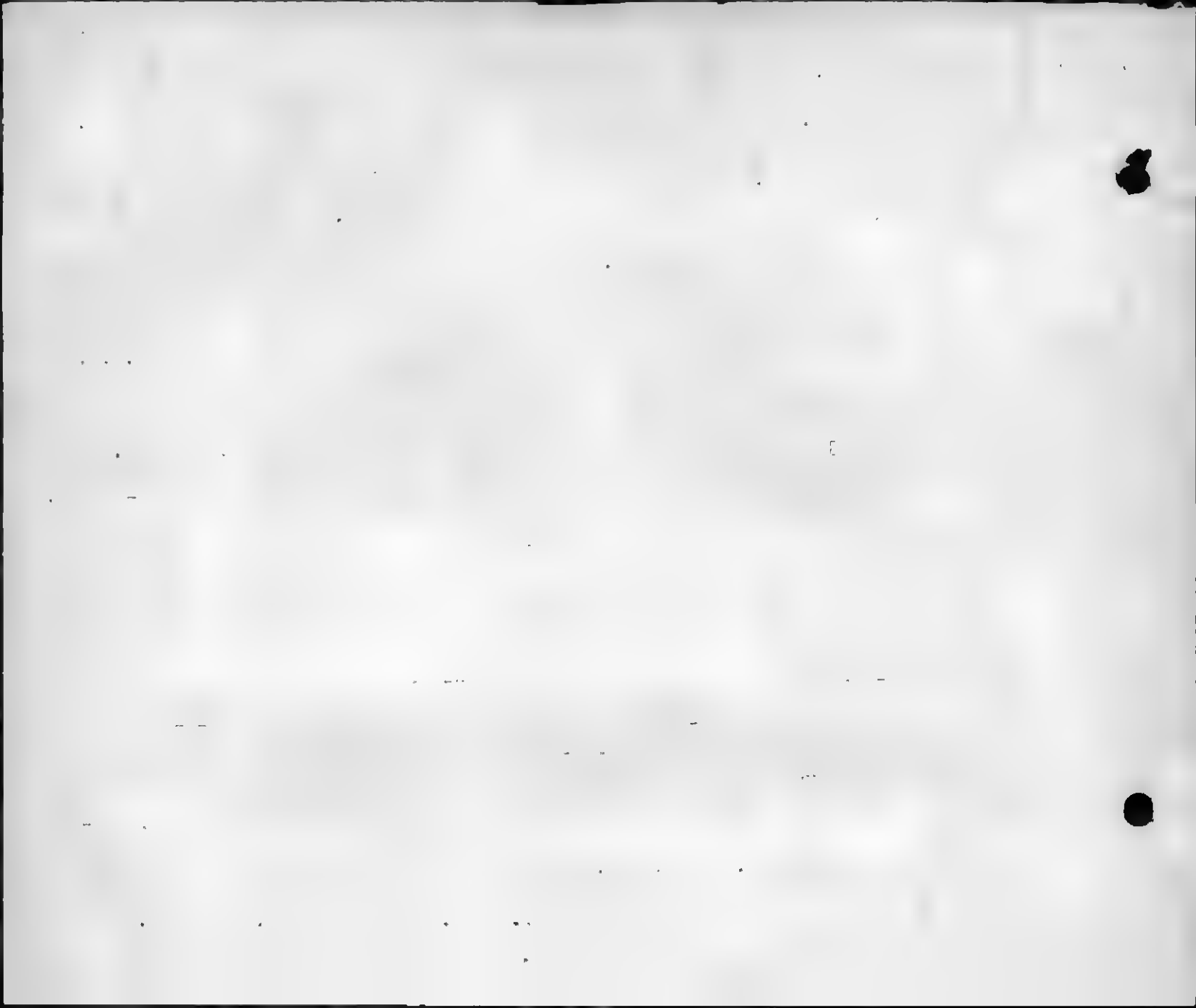
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0595 CERTIFICATE OF DEATH

Reg. Dist. No.

00692

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge, Maryland</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>401 Byan St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge, Maryland, Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF <u>Oliver T. Gray</u> (Type or print) First Middle Last		4. DATE OF DEATH <u>1 5 19 60</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/24/1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mailman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mailman</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Gray</u>		14. MOTHER'S MAIDEN NAME <u>Emily Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Le Compte Funeral Service, Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis, marked</u> DUE TO (c) <u>Arteriosclerosis generalized</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, mild</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-23-59</u> , 19 <u>59</u> , to <u>1-8-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-8-60</u> , 19 <u>60</u> , and that death occurred at <u>9:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u>		ADDRESS (Street, city or town, state) <u>15 Locust Street, Cambridge, Md.</u>	
DATE SIGNED <u>1-6-60</u>			
PHYSICIAN'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/8/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>JAN 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hous</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G254 1-18-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

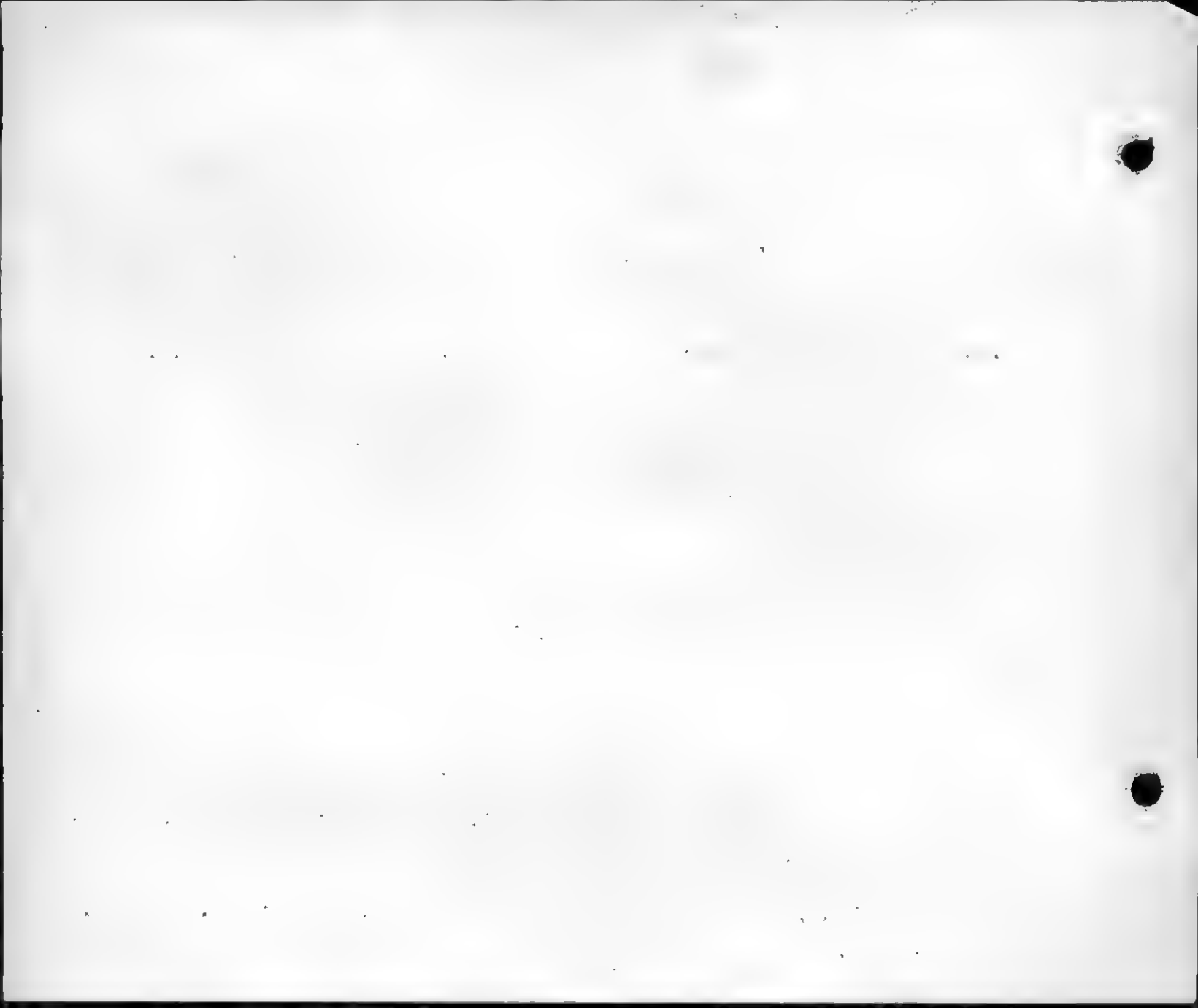
00603

0614

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN lb 14 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS Elk Mills	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIA Middle LYDIA Last HALEY		4. DATE OF DEATH Month Jan. Day 5 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/9/89
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Benson		14. MOTHER'S MAIDEN NAME Mollie Cox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 45a.0 DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Manic Depressive Reaction, Manic Type			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 5 , 19 53 , to Jan 5 , 19 60 , that I last saw the deceased alive on Jan 5 , 19 60 , and that death occurred at 3:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Galena, Kent Co., Md. DATE SIGNED 1-5-60			
ACTUAL SIGNATURE Thomas J. Dredge		M.D. E.S.S. Hospital, Cambridge, Md.	
PHYSICIAN'S NAME (Type) Thomas J. Dredge			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 9, 1960	22c. NAME OF CEMETERY OR CREMATORY Galena Cemetery	22d. LOCATION (City, town, or county) (State) Galena, Kent Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE William J. Dredge, M.D.		24a. REC'D BY REGISTRAR DATE JAN 8 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Dredge	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0596 CERTIFICATE OF DEATH

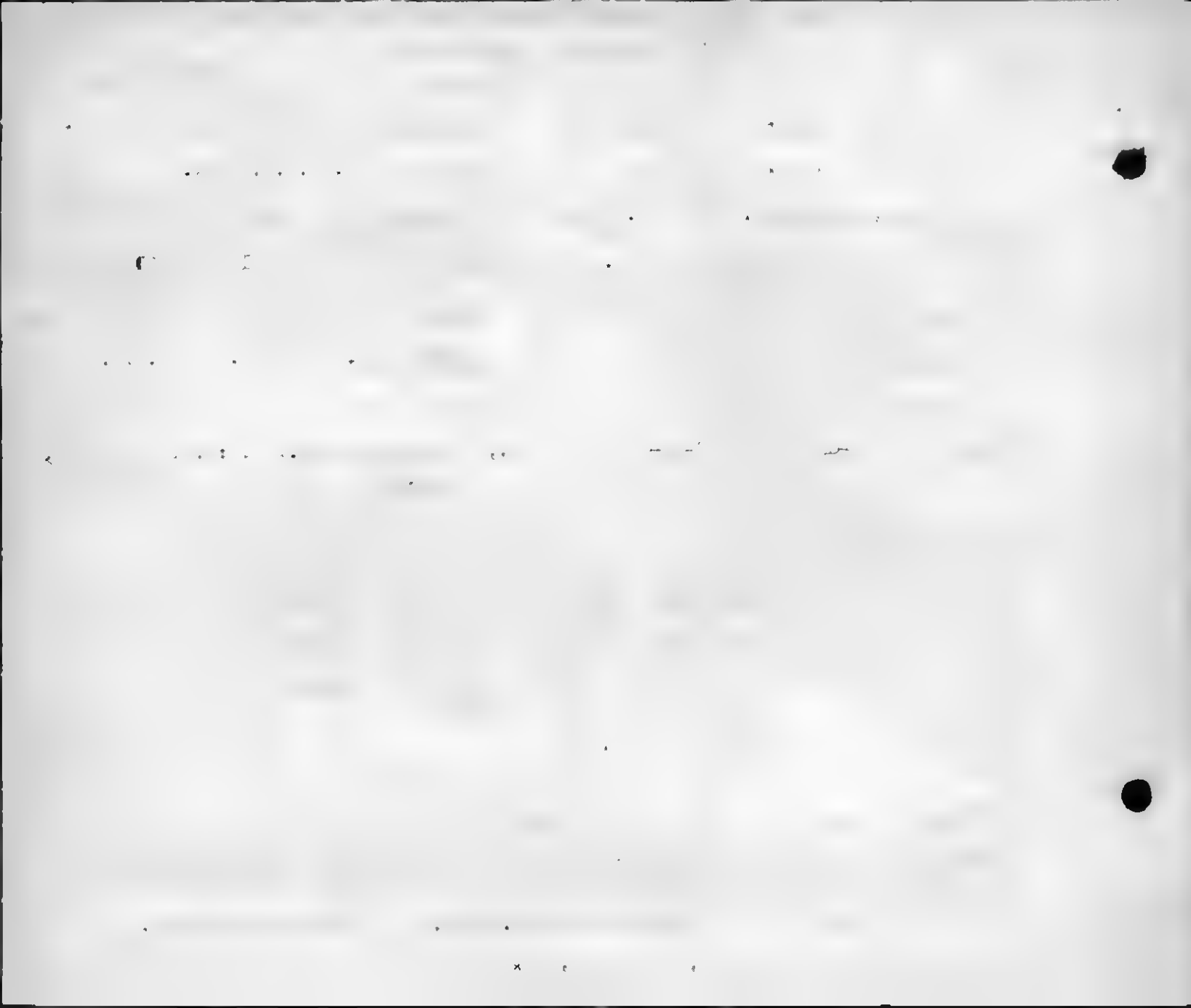
00604

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md. R.F.D. #1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge, Maryland, Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles H. Handley</u>				4. DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/18/1897</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>30</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Months <u>1</u> Days <u>30</u> Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co. Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Handley</u>				14. MOTHER'S MAIDEN NAME <u>Cobralia Seward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW-1</u>				16. SOCIAL SECURITY NO. <u>212-14-4276</u>		17. INFORMANT Address <u>Mrs. Charles Handley, R.F.D. #1 Cambridge, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> DUE TO (b) <u>1 day</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 day</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1/30/60</u> , 19 <u>60</u> , to <u>1/30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/30</u> , 19 <u>60</u> , and that death occurred at <u>8:40 P.M.</u> , from the causes and on the date stated above. DATE SIGNED <u>136 Race St.</u>							
ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u>				<u>Cambridge, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Le Compte Funeral Service, Cambridge, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2788

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64461

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY (If in hospital, give street address) 27yr. 9mo. 12das d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton d. STREET ADDRESS R.D. 4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hattie First P. Middle Hardin Last 4. DATE OF DEATH January 12 Month 19 Day 60 Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 6-14-77 9. AGE (In years last birthday) 82 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY - 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Towers 14. MOTHER'S MAIDEN NAME Sallie Payne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Unkn. (If yes, give war or dates of service) - 16. SOCIAL SECURITY NO. - 17. INFORMANT RECORDS - Eastern Shore State Hospital Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Instant	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr. EXAMINER'S NAME (Type) John Mace Jr. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/12/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1/15/60 22c. NAME OF CEMETERY OR CREMATORY Landing Neck Cemetery 22d. LOCATION (City, town, or county) (State) Talbot County, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Conell, Easton, Md. ADDRESS APR 19 '60 24a. REC'D BY REGISTRAR Arthur S. Kraus 24b. REGISTRAR'S SIGNATURE	

27



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00606

0597

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X East New Market			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rosalie B. Henry				4. DATE OF DEATH Month Day Year January 29 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/10/1899		9. AGE (in years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J.E. Boston				14. MOTHER'S MAIDEN NAME Maggie Phillips			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Percy Henry East New Market, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 120.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL/DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) East New Market		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) John Mace Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/31/60		22c. NAME OF CEMETERY OR CREMATORY East New Market		22d. LOCATION (City, town, or county) (State) East New Market Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John S. Kelloggby</i> ADDRESS East New Market				24a. REC'D BY REGISTRAR DATE FEB 5 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> 0598 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN lb <u>25 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>64 Douglas St.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u> d. STREET ADDRESS <u>1 64 Douglas St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Irving</u> Last <u>Irving</u>				4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/9/1898</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Butler Irving</u>				14. MOTHER'S MAIDEN NAME <u>Emma Irving</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-10-1370</u>		17. INFORMANT <u>Mrs. Maggie Irving</u> Address <u>64 Douglas St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John Mace Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>John Mace Jr. MD.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>1/25/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/26/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Dor. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert StClair</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 28 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur D. Hanks</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 3 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00608

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>0599</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland.</u>		d. STREET ADDRESS <u>9 Coader St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9 Coader St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Missouri</u> <u>Lankford</u>				4. DATE OF DEATH Month Day Year <u>1</u> <u>9</u> <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 2 1873</u>	9. AGE (In years last birthday) <u>87</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours M'n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Asora Hurley</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Horseman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Walter Daisey, Salisbury, Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>331X</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/10/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. F. ...</u>	



may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00699

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 125 Race St.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 125 Race St. • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clara E. Lewis First Middle Last 4. DATE OF DEATH Jan 22 19 60 Month Day Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 1, 1893 9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done, or nearest to it, if retired) House Wife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Meekins Travers 14. MOTHER'S MAIDEN NAME U known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. U known 17. INFORMANT Mrs Roland Burton Address Cambridge Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/21 , 19 60 , to 1/22 , 19 60 , that I last saw the deceased alive on 1/22 , 19 60 , and that death occurred at 11:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 Race St Cambridge, Md DATE SIGNED 1/23/60 ACTUAL SIGNATURE Lawrence Maryanov M.D. PHYSICIAN'S NAME (Type) Lawrence Maryanov Cambridge, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Jan 24, 1960		22b. DATE THEREOF Jan 24, 1960	
22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE DeCompte Funeral Service Cambridge Maryland		24a. REC'D BY REGISTRAR JAN 28 '60 24b. REGISTRAR'S SIGNATURE Arthur P. [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6615 CERTIFICATE OF DEATH

Reg. Dist. No.

10610

1. PLACE OF DEATH o. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> 20 40.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>		d. STREET ADDRESS <u>116 S. AURORA ST.</u>	
3. NAME OF DECEASED (Type or print) <u>L. FRANK</u> First Middle Last <u>LEWIS</u>		4. DATE OF DEATH <u>JAN. 21</u> 19 <u>60</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 23, 1905</u> 27 yrs
9. AGE (In years last birthday) <u>54</u> yrs		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE PAINTER</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FRANK LEVIN LEWIS</u>	
14. MOTHER'S MAIDEN NAME <u>SALLY BELL</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>UNKNOWN</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HOSPITAL RECORDS</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC MYOCARDITIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL THROMBOSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>57</u> , to <u>JAN. 21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JAN. 21</u> , 19 <u>60</u> , and that death occurred at <u>5:47 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Ettore DeFilippis</u> M.D.		EASTERN SHORE STATE HOSP.	
PHYSICIAN'S NAME (Type) <u>ETTORE DEFILIPPIS</u>		CAMBRIDGE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Jan 23, 60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Easton</u> <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellie R. Clark</u> ADDRESS <u>Easton MD</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>C. L. & K. H.</u>
		DATE <u>JAN 25 1960</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00611

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or reinterment, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> 0601 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u> c. LENGTH OF STAY IN 1b <u>B Hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge, Maryland, Hospital.</u>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linkwood, Maryland.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>W.</u> Last <u>Linthicum</u>			4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1960</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4/16/1930</u>		9. AGE (In years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR: Months <u>1</u> Days <u>13</u> Hours <u>18</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Linthicum</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Tyler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Le Compte Funeral Service, Records.</u> Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intercranial injury</u> <u>825x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture base of skull</u> (c) <u>825x</u> DUE TO (a) <u>825x</u> (b) <u>825x</u> (c) <u>825x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in auto accident</u>		20c. TIME OF INJURY Month, Day, Year <u>1/12/60</u> Hour <u>1:30</u> <u>am</u> p. m.			
20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Church Creek, Dor. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Dr. John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1/13/60</u>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/14/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Trinity Church Yard</u>	
22d. LOCATION (City, town, or county) (State) <u>Church Creek, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 14 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>					



0616

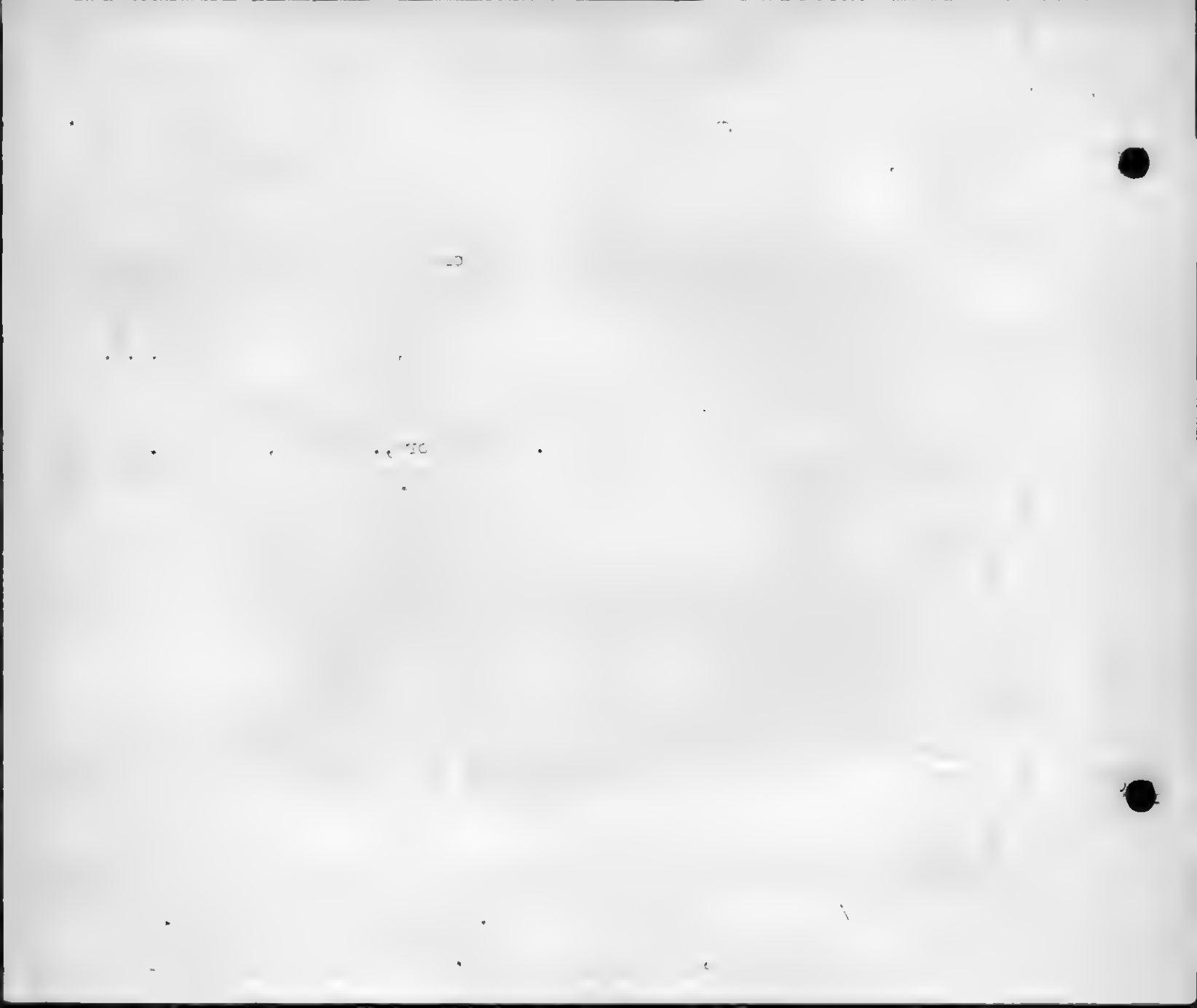
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andrews, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andrews, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leura Hughes Moore</u>				4. DATE OF DEATH Month Day Year <u>1 5 19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/11/1883</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Andrews, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levin Soloman Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mr. Gordy Moore, Andrews, Maryland.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2</u> DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROSIS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/27</u> , 19 <u>59</u> , to <u>1/5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/1</u> , 19 <u>60</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>136 RACE ST. CAMBRIDGE MD</u> DATE SIGNED <u>1/8/60</u>							
ACTUAL SIGNATURE <u>Alfred R. Maryanov</u> M.D.							
PHYSICIAN'S NAME (Type) <u>ALFRED R. MARYANOV</u>		<u>CAMBRIDGE MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/7/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Church Yard.</u>		22d. LOCATION (City, town, or county) (State) <u>Andrews, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland.</u>				24a. REC'D BY REGISTRAR <u>JAN 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

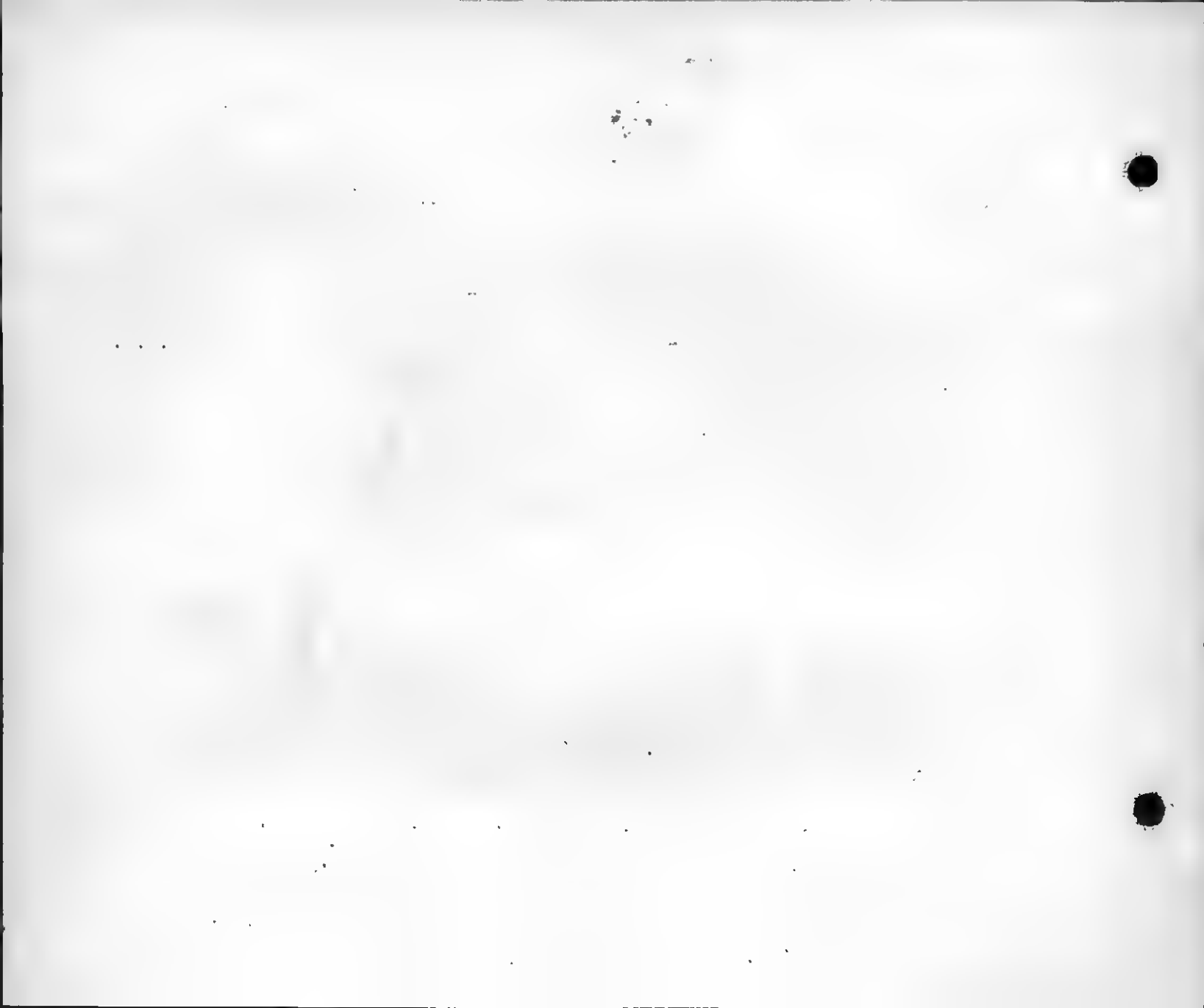


0617 CERTIFICATE OF DEATH

Reg. Dist. No.

00613

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 3yr. 5mo. 2das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
f. STREET ADDRESS 418 Willis Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NETTIE Middle MAY Last NORTH		4. DATE OF DEATH Month January Day 22 Year 19 60	
5 SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-19-85
9 AGE (In years last birthday) 74 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George North		14. MOTHER'S MAIDEN NAME Charlotte -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -	
INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 20, 1956 to Jan 22, 1960 , that I last saw the deceased alive on Jan 22, 1960 , and that death occurred at 4:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Thomas J. Dredge M.D. E.S.S. Hospital, Cambridge, Md. 1/22/60 PHYSICIAN'S NAME (Type) Thomas J. Dredge Kenneth R. Thomas			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1960	
22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas		24. REC'D BY REGISTRAR DATE JAN 27 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

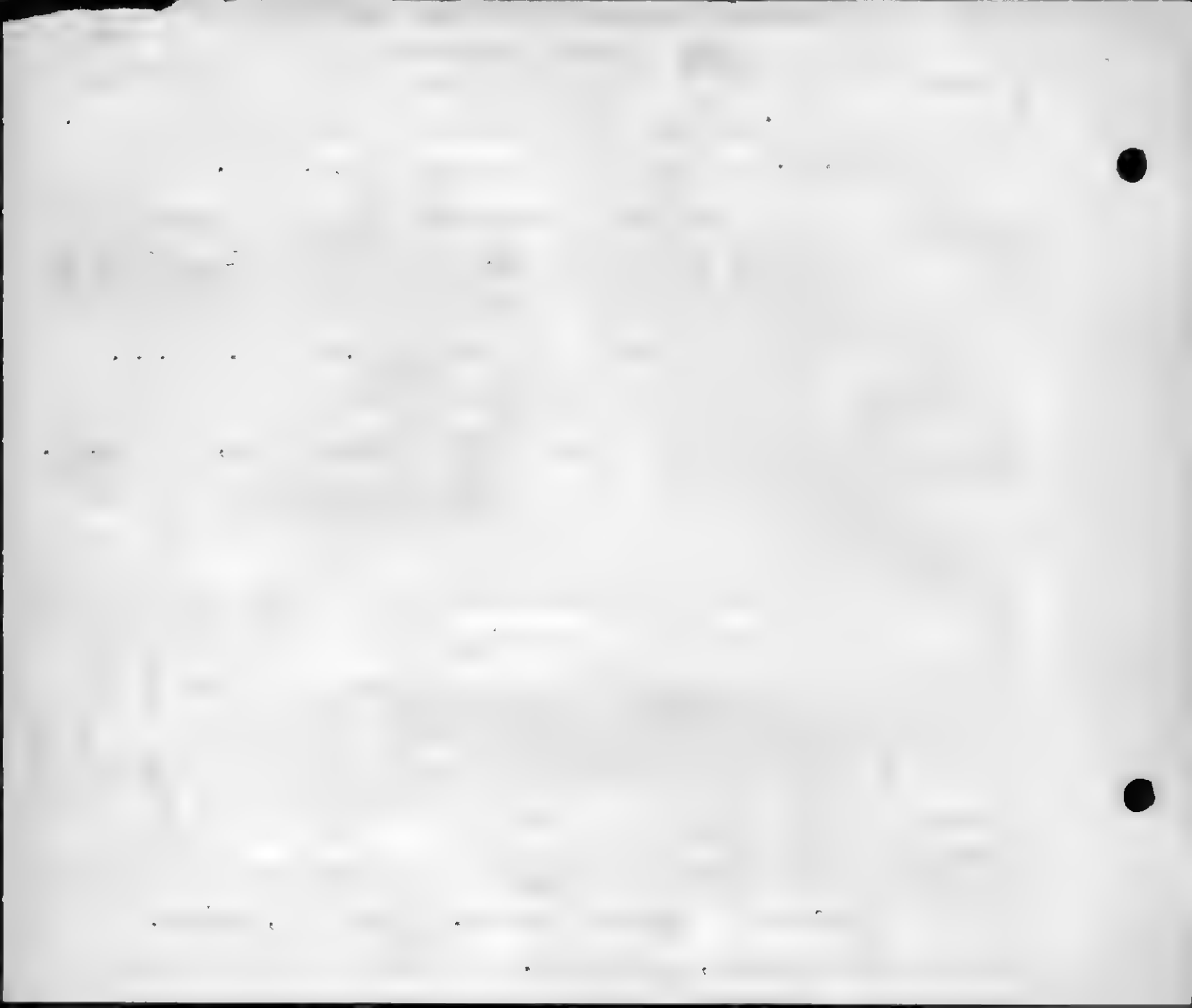
0618 CERTIFICATE OF DEATH

Reg. Dist. No.

00614

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Golden Hill, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Golden Hill, Maryland.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		e. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) First <u>Etta</u> Middle <u>Tyler</u> Last <u>Phillips</u>		4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/6/1872</u>
9. AGE (In years last birthday) yrs. <u>87</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co. Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jabez Tyler</u>		14. MOTHER'S MAIDEN NAME <u>Emily Goottee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Le Compte Funeral Service, Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Cardiovascular Disease</u> DUE TO (c) <u>10 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension Cardiovascular Disease - Congestive Failure</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-16</u> , 19 <u>58</u> , to <u>1-31</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-30</u> , 19 <u>60</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. B. [Signature]</u> M.D. <u>Cambridge</u>		DATE SIGNED <u>2-3-60</u>	
FURNER'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/3/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 8 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. [Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00615

Reg. Dist. No.

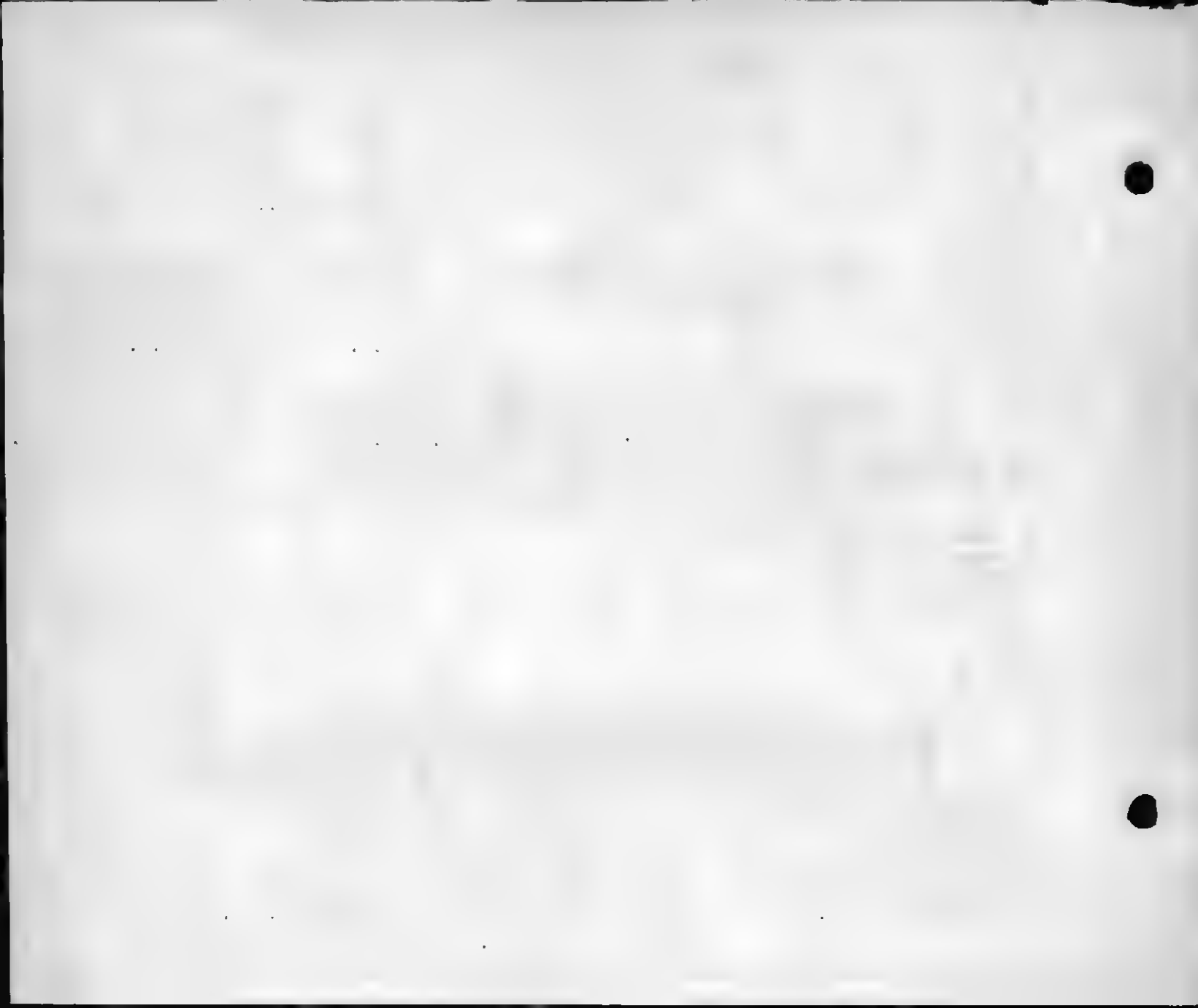
0602

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			c. LENGTH OF STAY IN 1b <u>49 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge-Maryland Hospital</u>				d. STREET ADDRESS <u>103 Glenburn Ave.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaretha Sticht Pink</u>				4. DATE OF DEATH Month Day Year <u>January 13, 1960</u> <u>19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 26, 1879</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>	
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Brooklyn, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Carsten Sticht</u>				14. MOTHER'S MAIDEN NAME <u>Gesena Brede</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Miss Nina E. Pink, 103 Glenburn Ave., Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 hr 40 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Dr. John Mace Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1/14/60</u>	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 15, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lemuel R. Lerner</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 1 8 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>C. L. Lerner</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00616

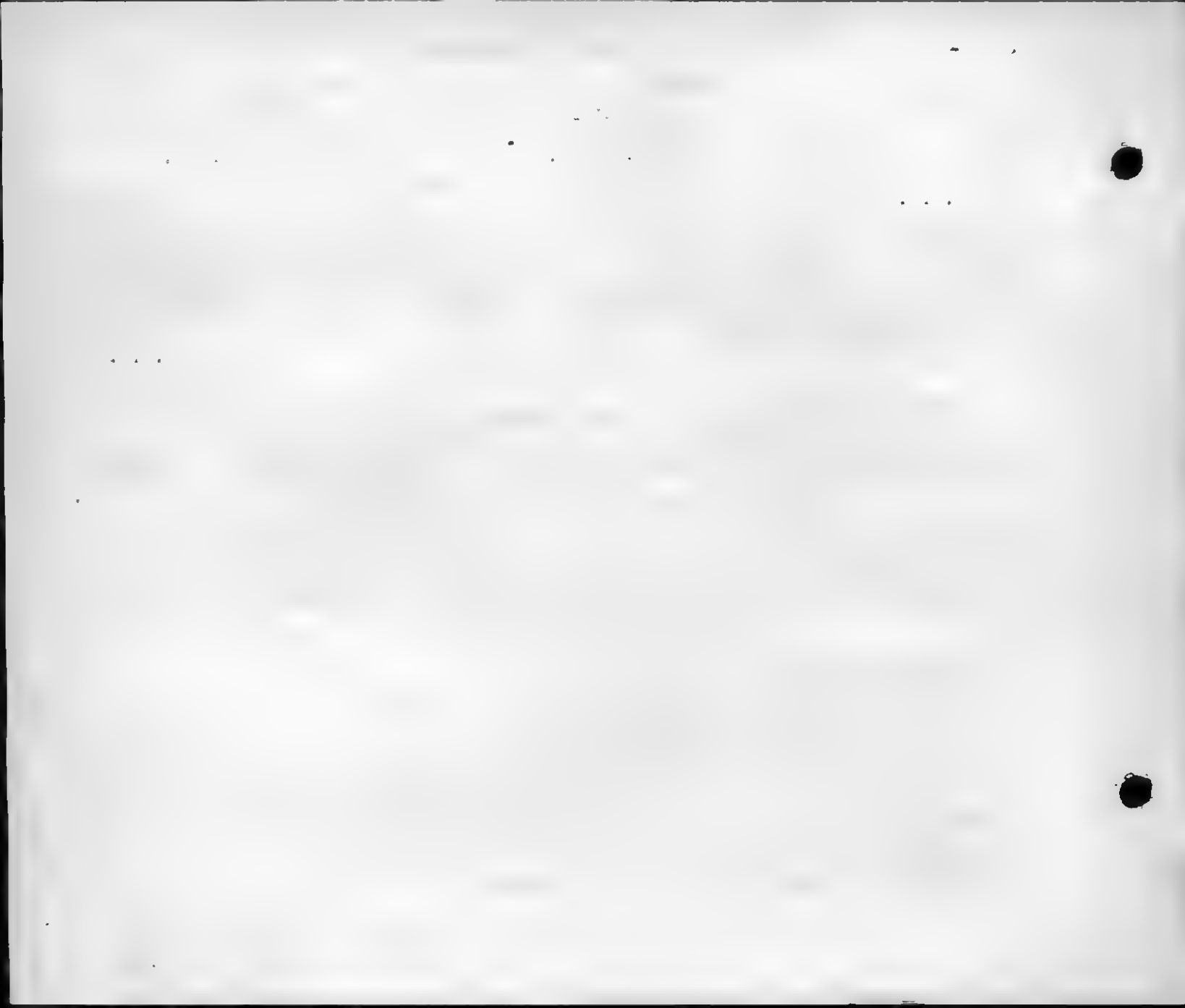
0619

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester, Maryland MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland		c. LENGTH OF STAY IN 1b 5YR.-10Mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge-Hoopersville, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) E.S.S. Hospital				d. STREET ADDRESS NOWE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cloria First Riggins Middle Lost				4. DATE OF DEATH Month 1 Day 9 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-80		9. AGE (= years last birthday) 79 yrs	IF UNDER 1 YEAR Months 1 Days 9	IF UNDER 24 HRS Hours 12 Min 45
10a. USUAL OCCUPATION (Give kind of work done during life, even if not paid) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James White				14. MOTHER'S MAIDEN NAME Clementine Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT EASTERN SHORE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 465X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 465X DUE TO cause lost (c)							INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>[Signature]</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James White				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/11/60		22c. NAME OF CEMETERY OR CREMATORY Laurel Mount Park		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE JAN 14 '60	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



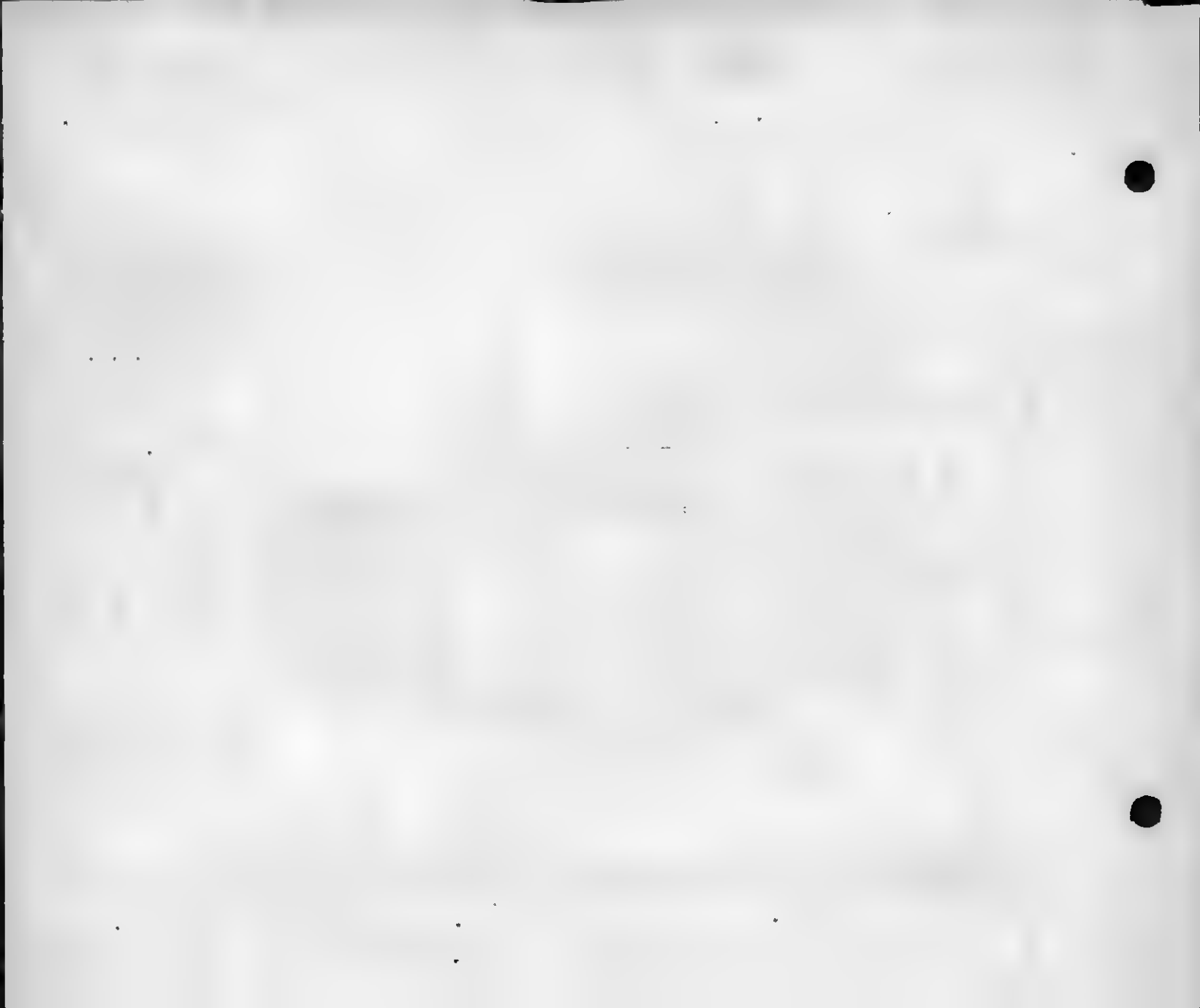
0603

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland</u>		c. LENGTH OF STAY IN 1b <u>6 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge, Maryland Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishops Head, Maryland</u>	
		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) First <u>Marea</u> Middle <u>Bayliss</u> Last <u>Robinson</u>		4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/17/1892</u>
9. AGE (In years last birthday) yrs. <u>67</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Bayliss</u>		14. MOTHER'S MAIDEN NAME <u>Georianna Bayliss</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-05-8027</u>	
17. INFORMANT <u>Le Compte Funeral Service, Records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Aortic Dissection</u> DUE TO <u>PARALYTIC ILLNESS</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) <u>Acute Ruptured Gallbladder 4 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/10</u> , 19 <u>49</u> , to <u>11/3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/3</u> , 19 <u>60</u> , and that death occurred at <u>8 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>104 HOLLY ST 1/4/60</u>	
PHYSICIAN'S NAME (Type) <u>W. H. HANKS</u>		<u>CAMBRIDGE, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/6/60.</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Robinson Family Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Bishops Head, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 14 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG-55 2-8-60 et

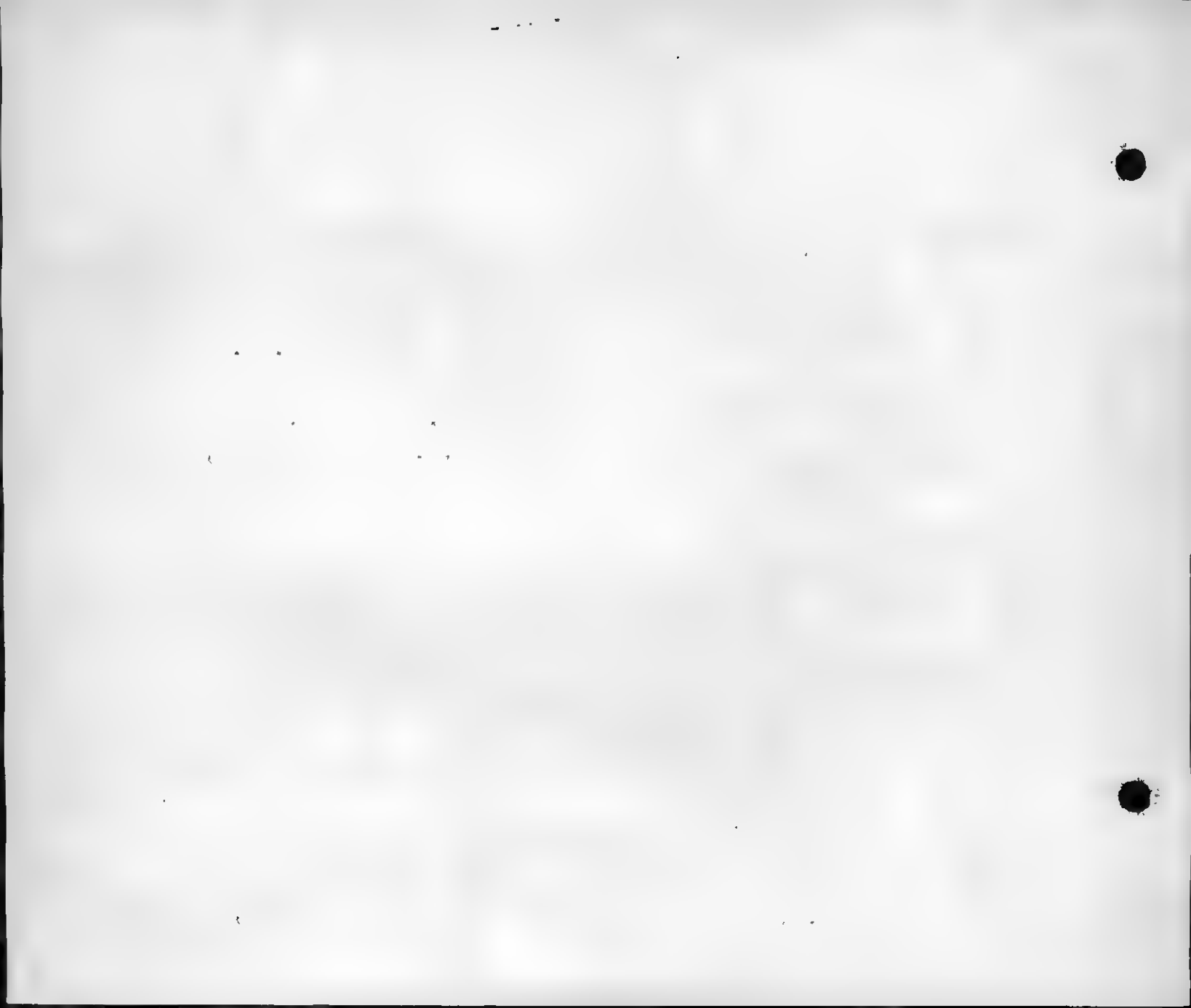
Reg. Dist. No.

00618

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> <u>MD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN SHORE STATE HOSPITAL</u>		e. STREET ADDRESS <u>R.F.D.#1(Union Rd)</u>	
3. NAME OF DECEASED (Type or print) <u>FRANK J. TOADVINE</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-98</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM HAND</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND Wico. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THEODORE F. TOADVINE</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE W. HALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u> No		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mr. Merrill W. Toadvine (Brother)</u>		18. EASTERN SHORE STATE HOSPITAL RECORDS <u>R.D.#4 Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>INSTANT</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		DATE SIGNED <u>1/30/60</u>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 3, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>	
ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 2 '60</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

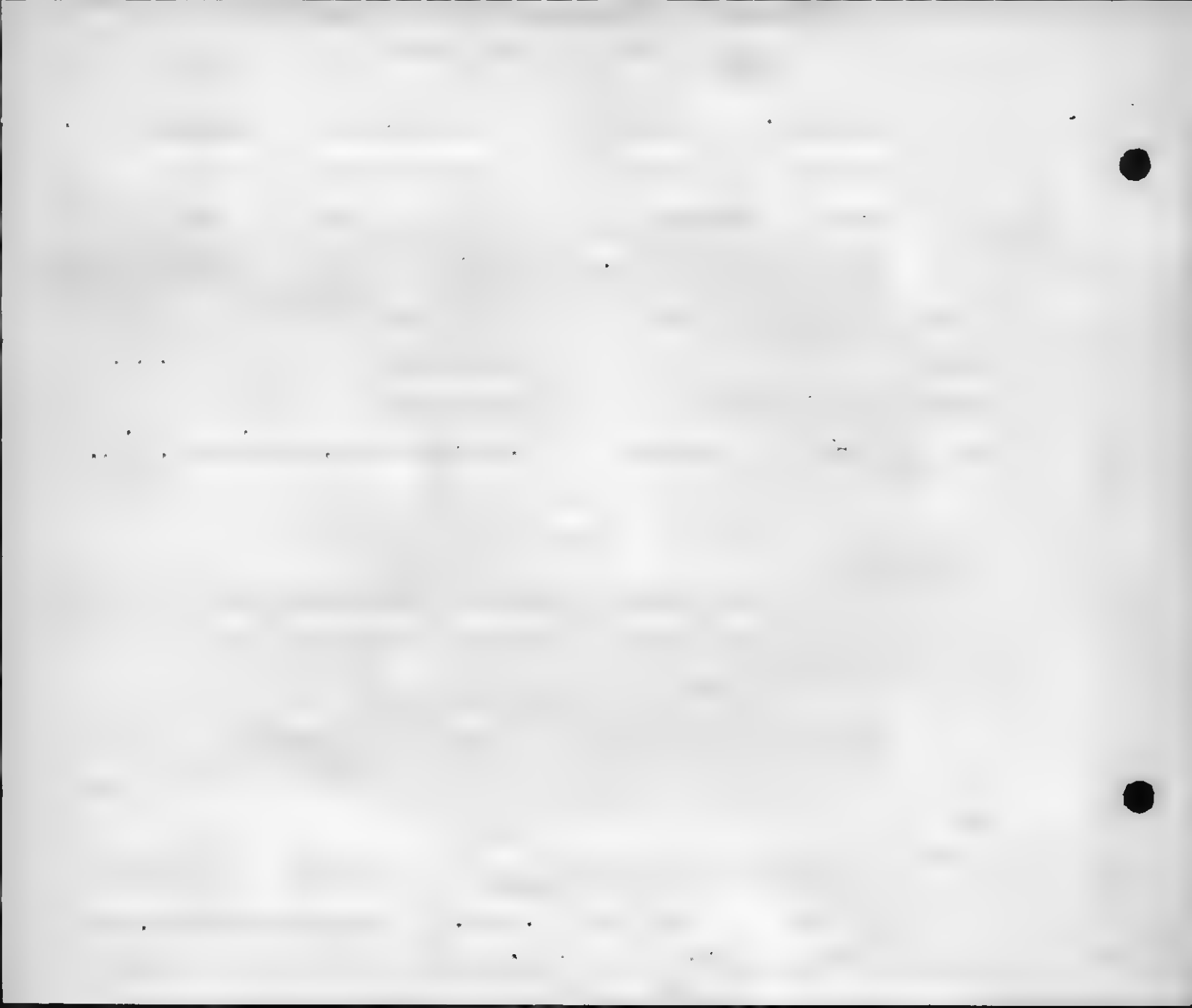
00619

0604

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland</u>			c. LENGTH OF STAY IN 1b <u>Life</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge, Maryland Hospital</u>				d. STREET ADDRESS <u>119 Choptank Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>G.</u> Last <u>Vickers</u>				4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1960</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/19/1887</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>				11. BIRTHPLACE (State or foreign country) <u>Taylors Island, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Greenbury Vickers</u>						14. MOTHER'S MAIDEN NAME <u>Harriet Geoghegan</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>WW-1</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT Address <u>Cambridge, Maryland.</u> <u>Mrs. Edward Vickers, 119 Choptank Ave.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Lung</u> DUE TO <u>With metastasis</u> (b) <u> </u> DUE TO <u> </u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>												INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>7/10</u> 19 <u>49</u> to <u>1/9</u> 19 <u>60</u> , that I last saw the deceased alive on <u>1/9</u> 19 <u>60</u> ; and that death occurred at <u>5 p</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Locust St. Cambridge, Maryland</u> ACTUAL SIGNATURE <u>W. H. H. Anks</u> M.D. <u>104 Locust St. Cambridge, Maryland</u> DATE SIGNED <u>1/9/60</u> PHYSICIAN'S NAME (Type) <u>W. H. H. Anks</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>				22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>										24a. REC'D BY REGISTRAR DATE <u>JAN 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton E. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00620

Reg. Dist. No.

0621

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vienna, Maryland</u>			c. LENGTH OF STAY IN 1b <u>Life</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>				e. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) First <u>Winfield</u> Middle <u>Scott</u> Last <u>Willey</u>				4. DATE OF DEATH Month <u>1</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>9/23/1890</u>		9. AGE (In years last birthday) <u>69</u> yrs. <u>6</u> months <u>28</u> days <u>19</u> hours <u>60</u> min.		10. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Daniel J. Willey</u>					
14. MOTHER'S MAIDEN NAME <u>Bertie Hughes</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>					
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Scott Willey Jr., Vienna, Md. R.F.D. # 1.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) <u>Arteriosclerosis generalized</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>---</u> a. m. <u>---</u> p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>			
20f. (City or town) <u>---</u>		(County) <u>---</u>		(State) <u>---</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>29th Jan. '60</u>			
EXAMINER'S NAME (Type) <u>Eldridge H. Wolff, M. D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
22b. DATE THEREOF <u>1/30/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park.</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>		ADDRESS <u>---</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 4 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		24c. REGISTRAR'S SIGNATURE <u>---</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Medical Examiner's Certificate of Death

125



124

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00621

0622

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md. R.F.D.#2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md. R.F.D.#2</u>	
c. LENGTH OF STAY IN 1b <u>40 Years</u>		d. STREET ADDRESS <u>None</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>A.</u> Last <u>Wingate</u>		4. DATE OF DEATH Month <u>1</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/12/1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Orange Co. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Bell</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Lewis Wingate</u>		Address <u>Cambridge, Md. R.F.D.#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension arteriosclerosis CVD.</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Constitutional failure (Cardiovascular)</u> DUE TO <u>Constitutional failure (Cardiovascular)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, type undetermined</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1959</u> to <u>Jan 27, 1960</u> , that I last saw the deceased alive on <u>Jan 22, 1960</u> , and that death occurred at <u>10:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. U. Thompson</u> M.D.		DATE SIGNED <u>Jan 28, 1960</u>	
PHYSICIAN'S NAME (Type) <u>James U. Thompson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/31/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service</u>		24a. REC'D BY REGISTRAR <u>FEB 4 '60</u>	
ADDRESS <u>Cambridge, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11-28

<p>NAME OF DECEASED <i>John A. Smith</i></p>		<p>DATE OF DEATH <i>Nov 28 1912</i></p>	
<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>	
<p>PLACE OF BIRTH <i>Johns Hopkins</i></p>		<p>DATE OF BIRTH <i>Nov 15 1867</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>PLACE OF DEATH <i>Johns Hopkins</i></p>	
<p>DATE OF INTERMENT <i>Nov 29 1912</i></p>		<p>PLACE OF INTERMENT <i>Johns Hopkins</i></p>	
<p>SIGNATURE OF PHYSICIAN <i>John A. Smith</i></p>		<p>SIGNATURE OF REGISTRAR <i>John A. Smith</i></p>	
<p>DATE OF SIGNATURE <i>Nov 28 1912</i></p>		<p>DATE OF SIGNATURE <i>Nov 28 1912</i></p>	